
A New Global Regulation on Public Health – Is the World Ready for A Second Treaty?

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Published: 28/02/2022

How to cite:

Mohamad, R., Budiarta, I, N, P. A New Global Regulation on Public Health – Is the World Ready for A Second Treaty?. *Sociological Jurisprudence Journal*. Volume 5 Issue 1. Page 1 - 7. <https://doi.org/10.22225/scj.5.1.2022.1-7>

Abstract

The World Health Organization (WHO) declared novel coronavirus (COVID-19) as a worldwide pandemic that has caused in high number of deaths in many countries and across national boundaries. In its early stage, governments all over the world have decided to implement lockdowns and closing of national border as ad hoc measures to slow down the drastic increase of the widespread of Covid-19. The United Nations through the UN General Assembly at its 74th session adopted Resolution on Global solidarity to fight COVID-19 recognized that this pandemic requires a global response based on unity, solidarity and renewed multilateral cooperation. The UN General Assembly passed under resolution on international cooperation to ensure global access to medicines, vaccines and medical equipment to face Covid-19 pandemic. This article is divided into three parts; the background of the current health security regulatory system under the International Health Regulations (IHR) 2005; the pursuance of pandemic treaty sponsored by WHO and 26 countries from Europe, Latin America and Asia and its justifications and the challenges ahead in resolving world pandemic regulatory system. The IHR aims for international collaboration "to prevent, protect against, control, and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks and that avoid unnecessary interference with international traffic and trade". There is a need to design a compulsory mechanism for alert to act much earlier and the alert system must be a build in compulsory mechanism. The compliance can only be made possible through the availability of coordination platform between WHO and other international organization like IMO, WTO and ICAO. Thirdly, United Nations General Assembly (UNGA) must play the vital role in giving the mandate to WHO to implement the coordination with other international organization. Hence, member states must therefore, give their political commitment in ensuring the successful coordination with other international agencies.

Keywords: COVID-19; international health regulation; challenges.

I. INTRODUCTION

The world is experiencing a new phase of unprecedented moment in the post globalization epoch since World War II since the declaration of Covid-19 pandemic by the World Health Organization (WHO) in March 2019. (The World Health Organization declared the outbreak a Public Health Emergency of International Concern on 30 January 2020, and a pandemic on 11 March 2020.) On March 11,2020, the World Health Organization (WHO) declared novel coronavirus (COVID-19) (WHO announced "COVID-19" as the name of this new disease on 11 February 2020) as a worldwide pandemic that has caused in high number of deaths in many countries and across national boundaries. (As of 29 August 2021, more than 215 million cases and 4.49 million deaths have been confirmed, making it one of the deadliest pandemics in history.) As much as it stimulates positive economic impact to many developing countries, equally, globalization has facilitated the worldwide spread of diseases (The WTO forecasts a 9.2% annual decline in merchandise trade for 2020 (WTO 2020) through the movement of people. (UN Report: Policy Brief: Covid - 19 and People on the Move, June 2020).

The magnitude of Ebola (the World Health Organization (WHO) reported cases of Ebola Virus Disease (EVD) in the forested rural region of south eastern Guinea, On March 23, 2014). throughout Western Africa, and Zika (Outbreaks of Zika virus disease have been recorded in Africa, the Americas, Asia and the Pacific.) In Latin America and the Caribbean are examples of wide spread of diseases giving rise to fears and dreads in many countries beckoning for unilateral action by governments to ban on movement of people from certain countries from entering their countries. (According to research carried out by United Nations specialized agency for tourism, UNWTO for the new report, as of 6 April, 96% of all worldwide destinations have introduced travel restrictions in response to the pandemic. Around 90 destinations have completely or partially closed their borders to tourists, while a further 44 are closed to certain tourists depending on country of origin.). In its early stage, governments all over the world have decided to implement lockdowns and closing of national border as ad hoc measures to slow down the drastic increase of the widespread of Covid-19 (managing the crisis across levels of government – 10 Nov. 2020).

Inevitably, country's economy is badly hit due to restricting or banning on movement of people and trade (Shrestha et al., 2020). Most governments are currently grappling in managing the crucial issue in the country, i.e., balancing the threat of public health and avoiding the fear of economic (Ibn-Mohammed et al., 2021).

Another development in the pandemic era of Covid-19 has witnessed the retrogress of regional solidarity (Kliem, 2020), where xenophobic sentiments runs high as depicted in Italy due to disenchantment of the European Union's slow response and failure to assist and support their member state to solve their public health issue.

The United Nations through the UN General Assembly at its 74th session adopted Resolution on Global solidarity to fight the Coronavirus disease 2019 (COVID-19) (UNGA Resolution 74/270) recognized that Covid-19 pandemic requires a global response based on unity, solidarity and renewed multilateral cooperation. The UN General Assembly passed under resolution on the international cooperation to ensure global access to medicines, vaccines and medical equipment to face Covid-19 pandemic.

The resolution further reaffirms the fundamental role of the UN systems in coordinating the global response to control and contain the spread of the Covid-19 disease and in support of member States and in this regard acknowledges the crucial leading role played by the WHO.

The United Nations Security Council on its part adopted a resolution on July 1, 2020 (Ilija Richard Pavone, 2021) and it demands, "a general and immediate cessation of hostilities in all situations on its agenda."; calls for all parties engaged in armed conflicts to "engage immediately in a durable humanitarian pause for its least 90 consecutive days".

II. METHOD

This article is divided into three parts; the first part examines the background of the current health security regulatory system under the International Health Regulations 2005; the second part discusses the pursuance of pandemic treaty sponsored by WHO and 26 countries from Europe, Latin America and Asia and its justifications and finally the challenges ahead in resolving world pandemic regulatory.

III. RESULTS AND DISCUSSION

World Health Security Regulatory System (The original International Health Regulations (IHR) were founded in 1969, but its underpinnings can be traced to the mid-19th century, when measures to tackle the spread of plague, yellow fever, smallpox and particularly cholera across borders, with as little interference to global trade and commerce, were debated. To address the realisation that countries varied with regards to their sanitary regulations and quarantine measures, the first of these series of early international sanitary conferences, convened in Paris in 1851, in the same year that telegraphic communications became established between London and Paris and when 12 nations attended, of which 11 were European States and three signed the resulting convention. The 19th century witnessed 10 of these conferences.)

Many of us are unaware of the existence and the working of International Health Regulations 2005 (IHR 2005) as a global binding instrument of international law that has entered into force on 15 June 2007 (The International Health Regulations (IHR), 2005) until the pandemic was declared by WHO in March

2020. At present, 196 countries across the globe have given their consent to implement the treaty with a view “to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.” (Article 2, IHR 2005) Since its inception in 1948, the international community relies on the World Health Organization (WHO) to combat diseases. Hence, the WHO is mandated to attain the highest possible health to the world citizens. (The implementation of these Regulations shall be guided by the Charter of the United Nations and the Constitution of the World Health Organization.)

As a signatory to the binding treaty, State is legally obligated under the International Health Regulation 2005 to notify any public health occurrence including potential communicable diseases which may constitute a Public Health Emergency of International Concern (A Public Health Emergency of International Concern, or PHEIC, is defined in the IHR, 2005) (PHEIC) within its territory to the WHO within 24 hours of assessment of public health information. Global Health Security (In S. Rushton & J. Youde (Eds.), Routledge Handbook of global health security (pp. 7–17). Routledge. [Google Scholar]; Nunes, J. (2015). The politics of health security. In S. Rushton & J. Youde (Eds.), Routledge handbook of global health security (pp. 60–70). Routledge) and its legal regime.

The International Health Regulations, or IHR 2005, represents a multilateral agreement between 196 countries including all WHO Member States to cooperate and work together to Due to the drastic increase in international movement of people travelling the globe and movement of trade in goods, and emergence and reemergence of international disease threats and other health risks, 196 countries across the globe have agreed to implement the International Health Regulations 2005 (IHR 2005) (Adam Ferhani & Simon Rushton, 2020).

This binding instrument of international law entered into force on 15 June 2007. (Under Articles 21(a) and 22, the Constitution of WHO confers upon the World Health Assembly the authority to adopt regulations “designed to prevent the international spread of disease” which, after adoption by the Health Assembly, enter into force for all WHO Member States that do not affirmatively opt out of them within a specified time period).

Through its regulatory system, most countries have consented to build their capacities to detect, assess and report public health events (The International Health Regulations (IHR), 2005). IHR 2005 also includes specific measures at ports, airports, and ground crossings to limit the spread of health risks to neighbouring countries, and to prevent unwarranted travel and trade restrictions so that traffic and trade disruption is kept to a minimum (Under the International Health Regulations, IHR 2005)

The stated purpose and scope of the IHR 2005 are “to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade (Article 2, IHR).

The state is under compulsory obligation to strengthen core surveillance and response capacities at the primary, intermediate and national level, as well as at designated international ports, airports, and ground crossings (Bartolini, G. 2021 - 233-250). They further introduced a series of health documents, including ship sanitation certificates and an international certificate of vaccination or prophylaxis for travelers ((Bartolini, G. 2021 - 233-250).

Non-compliance of Health Security and Regulatory System

It is interesting to note that in applying strictly the IHL 2005, many of the travel bans and restrictions implemented by state governments during the COVID-19 outbreak are in defiance of the treaty enforced. (Al Jazeera, 2020). The other area of defiance is in relation to the obligation of states to report their health measures to WHO. This is most troubling compliance of the treaty because as reported, at least two-thirds of these countries have not reported their additional health measures to WHO. Under IHR, states are legally obliged to inform and notify to WHO (Badker R, Miller K, Pardee C, et al, 2021). As many countries failed to regard the legal requirement to promptly report any additional health measures, WHO is handicapped and disabled to coordinate the world’s response to any catastrophic public health emergencies.

More importantly, unavailability of accurate reports leads to preventing countries from holding them legally accountable for their obligations under the IHR 2005.

Despite its legal effect, the unilateral action to ban or restrict travel by some countries with a view to prevent further escalation of the virus affecting the nationals of the countries are implemented by many countries. The practice by some of these states prove to be effective and thereby encourage other countries to do the same. However, the long-term effect would make global governance ineffective (Meier, B. M., Habibi, R., & Yang, Y. T., 2020). Following the traditional international law where key personalities are states and international organizations, as for now only states are subject to legal scrutiny and non-state actors like corporations and other non-governmental actors are outside the ambit of treaty obligation. In addition, the treaty is devoid of robust accountability mechanisms for compliance, enforcement, oversight, and transparency.

The Global Pandemic Treaty

While most states are currently struggling to cope with the Covid-19 pandemic, the World Health Organization (WHO) in their recent 74th World Health Assembly encouraged member states to consider negotiating a new Pandemic Treaty (Treaty) with an ambitious target of 2022 being the date open for signature (The Seventy-fourth World Health Assembly, Decided). The idea of a Treaty was first mooted by the EU Council President, Charles Michel (The Council adopted today a decision to support the launch of negotiations for an international treaty on the fight against pandemics. The World Health Assembly, the main governing body of the WHO, is expected to back the establishment of a process for a Framework Convention on Pandemic Preparedness and Response during its (virtual) meeting which starts on 24 May. The proposal for an international treaty on pandemics was first announced by the President of the European Council, Charles Michel, at the Paris Peace Forum in November 2020. At the European Council of 25 February 2021 EU leaders underlined the need for global multilateral cooperation to address current and future health threats and agreed to work on an international treaty on pandemics within the WHO framework and to advance global health security. On 30 March 2021, leaders from all around the world joined the President of the European Council and the Director-General of the World Health Organization, Dr. Tedros Adhanom Ghebreyesus, in an open call for an international treaty on pandemics. The draft decision was introduced by Chile, the European Union, Tunisia and Indonesia on behalf of the Group of Friends of the Treaty (Albania, Chile, Costa Rica, Croatia, Fiji, France, Germany, Greece, Indonesia, Italy, Kenya, Republic of Korea, The Netherlands, Norway, Portugal, Romania, Rwanda, Senegal, Serbia, South Africa, Spain, Thailand, Trinidad and Tobago, Tunisia, Ukraine, the United Kingdom). and later followed by the WHO Director General, Tedros Adhanom Ghebreyesus, together they and leaders of 26 countries of Europe, Asia, Africa and Latin America issued an open letter calling for a global treaty on pandemic prevention and preparedness and response. The commentary has been signed by J. V. Bainimarama, Prime Minister of Fiji; Prayut Chan-o-cha, Prime Minister of Thailand; António Luís Santos da Costa, Prime Minister of Portugal; Mario Draghi, Prime Minister of Italy; Klaus Iohannis, President of Romania; Boris Johnson, Prime Minister of the United Kingdom; Paul Kagame, President of Rwanda; Uhuru Kenyatta, President of Kenya; Emmanuel Macron, President of France; Angela Merkel, Chancellor of Germany; Charles Michel, President of the European Council; Kyriakos Mitsotakis, Prime Minister of Greece; Moon Jae-in, President of the Republic of Korea; Sebastián Piñera, President of Chile; Andrej Plenković, Prime Minister of Croatia; Carlos Alvarado Quesada, President of Costa Rica; Edi Rama, Prime Minister of Albania; Cyril Ramaphosa, President of South Africa; Keith Rowley, Prime Minister of Trinidad and Tobago; Mark Rutte, Prime Minister of the Netherlands; Kais Saied, President of Tunisia; Macky Sall, President of Senegal; Pedro Sánchez, Prime Minister of Spain; Erna Solberg, Prime Minister of Norway; Aleksandar Vučić, President of Serbia; Joko Widodo, President of Indonesia; Volodymyr Zelensky, President of Ukraine Dr Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization.

The exponent of the Treaty highlighted the main objective of the Treaty is to foster a comprehensive, multi-sectoral approach to enhance national, regional and global capacities and resilience to future pandemic. Going against the idea of the Treaty (See Dr German Velasques and Nirmalya Sham, 2021) disparagers questioned the need to have the Treaty when major issues like inequitable access to treatment

and taking concrete measures to counter the monopolies of pharmaceutical industry have not been responded with vigor by high income countries (See Acharya, K.P., Ghimire, T.R. & Subramanya, S.H. & David G Legge & Sun Kim, 2021). The crucial issue that must be addressed by member states of WHO is, first; whether the current global regulatory regime on health security is sustainable to cope with the pandemic responses? Secondly, will the Treaty assure an improvement of the shortcomings found in the current international regulatory system? The primary law and the only international legal treaty governing the outbreak of infectious diseases is the International Health Regulations (IHR), 2005. The IHR empowers the World Health Organization (WHO) to act as the main global surveillance system. In short, IHL provide the legal architecture outlining what governments must do to prevent, detect and respond to outbreaks of infectious disease. This includes sharing of information about emerging pathogens with the WHO and implementing public health interventions to prevent disease transmission.

The IHR 2005 came into force in June 2007, with 196 countries being state parties and recognizes that certain public health incidents, extending beyond disease, ought to be designated as a Public Health Emergency of International Concern (PHEIC), as they pose a significant global threat. It is interesting to note that since its inception, the objective of the IHR 2005 is not simply to prevent diseases. The IHR aims for international collaboration "to prevent, protect against, control, and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks and that avoid unnecessary interference with international traffic and trade". The legal mandate requires maintenance of a balance between national public health and international freedom of trade movement. Hence, there exist the inherent defect of the current regulatory regime. While pursuing its role to ensure and safeguard global public health within the domain of the WHO, freedom of trade movement is fundamentally state's jurisdiction. The necessity to collaborate through a transparency system in responding and reporting to health emergencies is the most fundamental focus of the global legal regime on health security. In realities, however, many governments failed to follow what has been legally agreed upon under the IHR 2005. Particularly, they defaulted in failure to report and unilaterally imposes travel ban and restrictions well before the declaration of the pandemic took place. Among the criticisms of present IHR is that it is technical and legal tools and delineating government's obligation to prevent, protect, detect and respond to emerging pathogens without empowering the WHO to enforce against those countries infringing the rules in the IHR is an inherent defect that need to be addressed. To ensure commitment by states there must be effective legal tools for enforcement. Then only compliance will be followed by states. Mindful that compliance of data sharing, upgrading of national capacity in term of health and medical treatment requires huge financial investment for poor countries, concrete measures to assist by high income countries must be seen to be in their priority list. So far, no real commitment has been demonstrated by rich countries.

Challenges

Like any global regulatory initiatives, the main challenge of the Pandemic treaty is that apart from being ambitious, its broad scope may make it challenging for the proposal to be universally accepted (See Jenny Lei Ravelo, 2021). The priorities of countries are diverse and in any diplomatic negotiations, unless and until several deals are made during the negotiations such a treaty may not be forthcoming despite its correct and true narratives. National priorities normally precede the global needs unless the carefully crafted treaty incorporates the priorities and demands of the states which outcome may be impracticable. (Steven J. Hoffman, John-Arne Røttingen, Julio Fren Am J, 2015). The other challenge is the government commitment to agree on the treaty would implicate submitting the part of their jealously guarded Westphalian construct sovereignty to the WHO when it comes to disease control. This would mean states will have to renunciate their sovereign power in matters pertaining to authority to share information, to recommend public health measures and to enhancing national capacity.

Achieving the ambitious goal in making the Treaty a reality will be subjected to a few conditions;

First, like any treaty, it needed countries to ratify and like in any multilateral agreements, this will take years until it is fully accepted. Meanwhile the process will require negotiations and compromises until fully accepted. Secondly, most developing and least developed countries do not have the luxury of experts to advise governments in highly technical areas. Hence, governments must allow researchers and NGO to

be actively involved to play their role in as far as providing expertise and specialization. Inclusivity of other than government bodies in matters concerning treaty negotiations are either unknown or least expected in those countries. Thirdly, the challenge of limiting the scope of the agreement to key issues focusing on the current shortcomings of IHR, for example, implementing an effective system for exchanging and verifying information on threats, as well as appropriate response mechanisms, monitoring of the implementation of the treaty's provisions, and enforcing responsibility for their violation. Fourthly, resolving the issue of seeking accountability, as well as the problem of verifying compliance with the new regulations, will also need to be addressed in the treaty. Fifth, addressing possible conflicts between the provisions of the new Treaty and the present IHR 2005, which could adversely affect the application of the standards contained in both. In this regard, the 30 March proposal that the IHR 2005 would strengthen the treaty is not sufficiently clear.

Reform of the present international health security system for preventing and responding to public health threats of international concern is necessary, and the proposals contained in the 30 March open letter must be seen to be a proactive attempt to re-evaluate the effectiveness of the current regulatory system and demands immediate response in time of pandemic. Of immediate concerns are in areas of improvement on alert systems, data sharing and transparency of state's legal commitment to response to health threats of international jurisdiction are some real examples that require immediate scrutiny for better global health regulatory regime. The area where IHR 2005 should be supported is the need to enhance technical and financial support to developing and least developing countries to assist them in meeting surveillance and response capacity requirements of IHR 2005. Mindful that immediate changes in the proposed new Pandemic Treaty can be challenging, hence, working on improving the current IHR 2005 would be most practical and can be seen acceptable by member states. In view of its intricacies that goes beyond public health, a totally independent body comprises of individual experts, non-governmental bodies, governments and international organizations should be established for the purposes of reviewing the current structure and governance of world health security without dispensing the crucial role played by the World Health Organization.

IV. CONCLUSION

It is evident that the current international health security regulatory system is a 'stand-alone' system. The uncoordinated unilateral actions taken by various governments during the pandemic Covid 19 and WHO playing the role to monitor the development of the situation is a testament that there is a dire need for coordinated effort between the various international organizations like ICAO, IMO and WTO to work closely with WHO. Reform of the whole health security regulatory system must consider the feasibility of harmonizing with international transportation system, trade of goods and movement of people. The fact that United States and most developed countries of Western Europe are unilaterally working on their own in fighting the invisible common enemy of Covid-19 clearly signaled the need to establish consultative mechanism among states. Despite IHR 2005 being a treaty, the needed reform should be hard legal instrument leaving no room for soft instrument approach. First, there is a need to design a compulsory mechanism for alert to act much earlier and the alert system must be a build in compulsory mechanism (Kumanan Wilson, John S Brownstein, David P Fidler, 2010). Secondly, compliance can only be made possible through the availability of coordination platform between WHO and other international organization like IMO, WTO and ICAO. Thirdly, United Nations General Assembly (UNGA) must play the vital role in giving the mandate to WHO to implement the coordination with other international organization. Hence, member states must therefore, give their political commitment in ensuring the successful coordination with other international agencies. There is also a need to reflect on food (See Fernando O. Mardones, Karl M. Rich, et al, 2020) and agriculture connection health security regulatory system. Much has been debated in the medical and science fraternity how human is affected by animal health and food production. (Reddy B, L, Saier M, H, Jr (2020). The IHL 2005 must be made possible to accommodate the badly needed protection for migrant workers and refugee's health security and basic human rights protection in time of pandemic widespread of disease. (Noman, H., Dureab, F., Ahmed, I. et, 2021). As a legally binding system for protecting people worldwide from the global spread of disease, the IHL must be seen to be complied with and observed by all the signatory states. (Chayes, Abram & Chayes,

Antonia (1998). Finally, the implementation of an effective health security regulatory system must not be limiting the sovereign right of every state. Rather, in unprecedented time what is desperately needed is the cooperation and solidarity movement through science and technology diplomacy to ensure peace and health security is maintained in this world. (Paunov, C. and S. Planes-Satorra, 2021)

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